

Case Number:	CM13-0061559		
Date Assigned:	12/30/2013	Date of Injury:	04/24/2012
Decision Date:	06/10/2014	UR Denial Date:	11/26/2013
Priority:	Standard	Application Received:	12/05/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in General Surgery and is licensed to practice in Texas. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 51 year old male who sustained an injury on 04/24/12 when he twisted the left ankle falling forward. Per the case notes, the patient's date of injury was actually 03/04/11. The patient is noted to have had a prior surgery to the left ankle and has had a history of narcotics use since 2012. The patient did also describe headache symptoms following the injury. The patient is noted to be a diabetic and was found to have evidence of a left median nerve compression finding consistent with carpal tunnel syndrome and was recommended to see an orthopedist in October of 2012. The patient was recommended for a left carpal tunnel release in September of 2013. The patient was seen by [REDACTED] on 09/27/13 with complaints of persistent pain in the left wrist with associated numbness and weakness. Medications at this visit included Ultracet, Naproxen, Protonix, and Norco. Physical examination noted tenderness to palpation in the left wrist with positive Tinel's signs. In combination with the proposed left carpal tunnel release, the patient was recommended for preoperative clearance, laboratory studies, general anesthesia with the use of a pain catheter, Rejuveness, Amoxicillin for postoperative infection, Zofran for postoperative nausea, Gabapentin postoperatively for neuropathic pain, and the continuation of Norco for postoperative pain. The patient was also recommended to see a pain specialist in order to help reduce medications over time. Follow up with [REDACTED] on 10/30/13 indicated the patient was pending certification for the proposed left carpal tunnel release. The patient's left carpal tunnel release was certified on 11/26/13. Follow up with [REDACTED] on 12/05/13 indicated the patient was still pending surgical intervention. The patient did have recent surgery on the foot which was healing. Per the report, the patient was scheduled for his left carpal tunnel release in January of 2014. The patient was recommended for continued use of Norco, Ultracet, Naproxen, and Protonix as well as referral to pain management for reduction of pain medications. The patient was seen by [REDACTED] on 01/02/14. Per the report, the patient did

attend a preoperative clearance evaluation from [REDACTED] which found no contraindications for surgical intervention. The patient was reported to have side effects from medication use to include upset stomach for which Protonix was beneficial. The patient did report pain relief with the use of Ultracet and Naproxen as well as Norco.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

NORCO 10/325 MG #180: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria For Use Page(s): 88-89.

Decision rationale: In regards to the request for Norco 10/325mg, quantity 180, this reviewer would have recommended this medication as medically necessary. The patient was utilizing Norco for pain control in regards to left carpal tunnel symptoms. The patient was noted to be scheduled for surgical intervention in January of 2014. The patient was recommended to continue with Norco for preoperative pain control as well as postoperative pain control. There was no evidence of any aberrant medication use which would have provided concerns regarding the continuation of Norco. The patient did report functional improvement and pain control with Norco. Therefore, this medication is medically necessary for the time period in question.

PAIN CATHETER: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Post-Operative Pain Pump.

Decision rationale: In regards to the use of a pain catheter, this reviewer would not have recommended this postoperative treatment as medically necessary. The clinical literature does not support the use of pain catheters as compared to standard postoperative pain control utilizing either oral or IV medications. In this case, the patient could have reasonably achieved proper pain control with Final Determination Letter for IMR Case Number CM13-0061559 4 either of these medication routes and did not require placement of a permanent pain catheter. Therefore, this would not be recommended as medically necessary.

SLING LEFT WRIST: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, & Hand Chapter, Splints.

Decision rationale: In regards to the request for a sling for the left wrist, this reviewer would not have recommended this durable medical equipment as medically necessary. There is no evidence of any substantial instability in the left wrist that would have required extensive surgical procedures thus requiring a postoperative sling. The left carpal tunnel release proposed for this patient would not have reasonably required postoperative durable medical equipment to include a sling. Therefore, this would not be recommended as medically necessary.

REJUVENESS: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation S. O'kane. Wound Remodelling And Scarring. Journal Of Wound Care, Vol. 11, ISS. 8.

Decision rationale: In regards to the request for Rejuveness, this is an over the counter available scar management silicone sheet. This does not require a prescription and can be obtained over the counter. There is no indication that this over the counter silicone sheet results in any substantial postoperative improvement as compared to standard postoperative healing. Therefore, this would not be recommended as medically necessary.

PRE-OPERATIVE HISTORY AND PHYSICAL: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation AHRQ National Guidelines Clearinghouse, Interventions and Practices Considered, Preoperative Assessment.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Pre-Operative Testing, General.

Decision rationale: In regards to the request for a preoperative history and physical, the clinical documentation submitted for review indicates that this has been performed. Given that the patient was noted to have a diagnosis of diabetes, a preoperative history and physical would have been medically necessary in order to rule out any significant comorbid issues that would have contributed to elevated risk factors for surgical intervention. Therefore, this would be recommended as medically necessary.

URINALYSIS: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation AHRQ National Guidelines Clearinghouse, Interventions and Practices Considered, Preoperative Assessment.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Pre-Operative Lab Testing.

Decision rationale: In regards to the request for a urinalysis, this reviewer would have recommended this laboratory test as medically necessary. The patient was pending surgical intervention and had a noted diagnosis for diabetes. Urinalysis to confirm renal function prior to any surgical intervention for a diabetic patient would be considered standard of care. Therefore, this would be recommended as medically necessary.

CHEST X-RAY: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation AHRQ National Guidelines Clearinghouse, Interventions and Practices Considered, Preoperative Assessment.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Pre-Operative Testing, General.

Decision rationale: In regards to the request for a chest x-ray preoperatively, this reviewer would have recommended this preoperative assessment as medically necessary. The patient is noted to have comorbid issues to include diabetes and chest x-rays prior to any surgical intervention to rule out other risk factors for complications would have been reasonable and medically appropriate. Therefore, this would be recommended as medically necessary.

ZOFRAN 8 MG #20: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Center for Biotechnology Information.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Antiemetics.

Decision rationale: In regards to the request for Zofran 8mg, quantity 20, this reviewer would have recommended this medication as medically necessary for postoperative use only. The patient was pending a left carpal tunnel release in January of 2014. Postoperative nausea is a common side effect for most patients and Zofran is FDA indicated to address postoperative nausea. Therefore, this would be recommended as medically necessary.

PROTONIX 20 MG #60: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Proton Pump Inhibitors.

Decision rationale: In regards to the request for Protonix 20mg, quantity 60, this reviewer would have recommended this medication as medically necessary based on review of the clinical documentation submitted as well as current evidence based guidelines. The patient is noted to have gastrointestinal side effects with multiple medications per the clinical record. Given the side effects with medications, Protonix as a proton pump inhibitor would have been supported as medically necessary.

NAPROXEN 550 MG #60: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67-68.

Decision rationale: In regards to the request for Naproxen 500mg, quantity 60, this reviewer would have recommended this medication as medically necessary for both pre and postoperative use. In this case, the patient did report functional improvement and reduction in symptoms with the use of Naproxen. Given the amount of postoperative swelling expected for this patient, use of an antiinflammatory would have been reasonable and medically appropriate. Therefore, this would be recommended as medically necessary.

ULTRACET 37.5/325 MG #60: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 94-95.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria For Use Page(s): 88-89.

Decision rationale: In regards to the use of Ultracet 37.5/325mg, quantity 60, this reviewer would have recommended this medication as medically necessary. The patient did report functional improvement and pain reduction with this medication. Given the amount of expected postoperative pain, this prescription would have been reasonable and medically appropriate for this patient. Therefore, this would be recommended as medically necessary.

RETRO: PROTONIX 20 MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Proton Pump Inhibitors.

Decision rationale: In regards to the request for Protonix 20mg, quantity 60 retrospective use, this reviewer would have recommended this medication as medically necessary. The patient is noted to have gastrointestinal side effects with oral medications. Given the side effects, the previous use of Protonix would have been medically appropriate to address side effects and allow for the patient to continue taking prescribed medications. Therefore, this would be recommended as medically necessary.

REFERRAL TO PAIN SPECIALIST: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS ACOEM Guidelines, Chapter 7, Page 127.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, page 127.

Decision rationale: In regards to the request for referral to a pain specialist, this reviewer would have recommended this request as medically necessary. The patient has had a long history of medication use to include narcotic medications. Other medications have included antiinflammatories and Ultracet. Given the amount of postoperative pain expected for this patient, a referral to a pain specialist would be reasonable in order to streamline the prescribed medications and affect a weaning period in order to have the patient reduce and eliminate pain medications postoperatively as recommended by guidelines. Therefore, this would be recommended as medically necessary.